Mentoring & Counseling Center

Teresa Kline, MA, LPC
Licensed Professional Counselor
972-268-9258

Informed Consent Agreement (Parent Copy)

Training and Background of Teresa Kline

Experience in the Mental Health Field—since 2000.
Licensed by the Texas State Board of Examiners of Professional Counselors.
Master of Arts Degree in Counseling-Liberty University-2000.
Certificate-Light University-Addiction and Recovery-30 hours.
Certificate-Light University-Relationship Coaching-12 hours.

What to Expect

"My goal is to provide a space where your Teen feels welcomed and accepted.
And I am committed to providing your Teen with the best quality of care. Based on the set of concerns your Teen brings to the first session, I will determine if I believe that I have the expertise to assist them with these concerns. If your Teen's primary concern is outside of my area of expertise, I will provide referrals for you.

My goal is also to assist your Teen in reaching his or her desired goals. At the close of the first session, I will recommend frequency of sessions. As counseling progresses, parents are always welcome to reach out with any concerns. Although I do not routinely contact the parents, I do reach out when there is a concern in regard to possible need for referrals and/or in case of safety concerns.

Note: Specific treatment outcomes are neither implied nor guaranteed.

Confidentiality

It is your Teen's right that sessions and records are kept private. Your Teen's confidentiality is protected by the rules of the Therapist's profession, the Therapist's personal integrity, and state law--except for a few rare instances. Texas state law requires that Clients be informed that in certain cases confidentiality is not protected, and Client information may be disclosed to the appropriate authorities/ agencies. These cases are:

* If Therapist has reason to believe that Teen Client may harm self or others
* If Teen Client reports being sexually abused.
* If Therapist has reason to believe that Teen Client is involved in or has knowledge of abuse or neglect of a child; or abuse, neglect or exploitation of a person who is elderly, or has a disability.

In either case above, the Counselor is required to contact CPS/APS.
Or * If Therapist is ordered to disclose by state or federal courts.

Parent/Guardian Initials _____ **Therapist Initials _____**

Informed Consent Agreement (cont.)

Emergencies

The Office phone number is 972-268-9258 for scheduling appointments and to leave non-emergency messages. Messages will be returned within 24 hours. In case of an emergency, or if you need immediate assistance for any reason, please call the 24-hour crisis hotline @ 866-260-8000 (North Texas Behavioral Health Authority).

Financial Matters-Insurance: (Payment is due at time of service)

Co-pay is $____ unless there is a deductible that has yet to be met.

In this case, payment due for sessions is $______ until deductible has been met.
Payment options: HSA card, VISA, Mastercard, cash, check.
* **If for any reason insurance does not pay for services rendered, payment of $80 per session is the Parent's responsibility.**

Financial Matters-Non-Insurance: (Payment is due at time of service)

The rate for each session is **$85** for Clients who are not paying via insurance**.**
*If payment is made by check, please make checks payable to "Teresa Kline."
* VISA, Mastercard, and HSA card are also accepted.

. . . .

Sessions are 50 minutes.

Write your initials beside "Yes" or "No" below in regard to giving permission for means of communications with your Teen in regard to appointments/scheduling:

Voice Mail: __Yes __No **Mail**: __Yes __ No **Email**: __Yes __ No **Text:** __Yes __ No

Write your initials beside "Yes" or "No" below in regard to giving permission for means of communications with you, the Parent:

Voice Mail: __Yes __No **Mail**: __Yes __ No **Email**: __Yes __ No **Text:** __Yes __ No

Office policy in regard to missed appointments: If you need to cancel or reschedule, please give 24-hour notice in advance.

There is a $50 fee for No Show appointments.

I have read and understand the information above.

______________________________ ______________________

Parent/Guardian Signature **Date**

______________________________ ______________________

Therapist Signature **Date**

Informed Consent Agreement (Parent Take-Home Copy)

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ADOLESCENT CLIENT REGISTRATION:

Parent/Guardian Information:

Name ______________________________________Phone______________________________

Email Address____

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Adolescent/Client Information:

Last/First Name ____

Home Address____

____Phone:______________________________

Age________ Date of Birth_________________ Family Physician__________________________

Current Medications: ____

Referred by: ____Insurance ____Internet ____Family/Friend

Has client been to counseling before? ________ If yes, When? ____________________________

Previous Mental Health Inpatient Episodes? _____ If yes, When? _________________________

Previous Mental Health Diagnosis: ____

. . . .

Clients Covered by Insurance Please complete/sign below:

Co-pay is payable at time of each session. Your Therapist will submit bill to the insurance company for the remaining portion of charges due. Your signature authorizes such payments to be sent directly to Teresa Kline, MA, LPC. Your signature also authorizes the release of information necessary to process the claim.

Parent/Guardian Signature ___________________________________ Date _______________